Request Reference: FOI/006/21
Published: 01 June 2021

Information requested:
I am writing to request blank template forms for:

1. Social Work assessment form for inpatients.
2. Care and treatment plan for inpatients
3. Admission assessment form for patients being assessed for admission
4. Discharge summary form

Response:
1. We have enclosed Social Work Admission Assessment Report,
2. Social Work Intermediate Report, Social Work Annual Report, CPA & NCPA
3. Social Work Pre Admission Assessment Report & The State Hospital Pre-Admission Assessment
4. Social Work Transfer / Discharge Summary

Question 1:

Social Work assessment form for inpatients

Address:
Client ID:

Close

DoB: Gender::

Social Work Admission Assessment Report

Client					
Date/time					
CHI:		**RMO:**		**Ward:**	
Admission Case Conference Date:					

Basis of Report

Index Offence(s)

Victim Issues

Education and Employment History

Relationship and Support Network

Accommodation and Financial Circumstances

Child Protection and Welfare Issues

Adult Protection Issues

Patient's View

Named Person/Carer's View

Address:
Client ID:

Close

DoB: Gender::

Social Work Admission Assessment Report

Professional Views				
Risk Issues				
Additional Information				
Executive Summary (Recommendation/Forward Planning)				
Content of report discussed with patient?	Yes	**If yes, date report content was discussed with patient**		**If no, please state reason**
Completed by (Social Worker)		**Date**		
Selecting this box signifies that the assessment is ready to be reviewed and closed off by a Team Leader.				
Assessment ready to be reviewed?				
Reviewed by (Team Leader)		**Date**		
Please be aware that it is the responsibility of the Team Leader to close this record.				
Once all relevant information has been entered, please close the record by selecting the Close Record tick box below. Please note that once this box has been selected, and the form has been saved, the record will become Read Only and no further edits will be possible.				
Updated by				
Updated on				

Question 2:

Care and treatment plan for inpatients

THIS REPORT CONTAINS THIRD PARTY INFORMATION Yes/No

SOCIAL WORK REPORT
Annual Report

NAME:	**HUB:**
DATE OF BIRTH:	**CHI NO:**
HOSPITAL NO:	**RMO:**

CURRENT LEGAL STATUS:	
ORDER END DATE:	
PQD:	
EDL:	
SED:	
DATE OF ADMISSION:	
ADMITTED FROM:	
INDEX OFFENCE(S):	

Notifiable under Part 2 Sexual Offences Act 2003(2)	
Sex Offender	
Schedule 1 Notification	
Risk to Children	
Subject to MAPPA	
Restricted Patient	
Treated as Restricted	

Named Person *(name, address and telephone details)*	
Primary Carer ***(if different from above)***	
Advance Statement	
Designated MHO *(name, address and telephone details*	
Local Authority	

Social Work Service, The State Hospital, Carstairs ML11 8RP
Tel: 01555 840293 Fax: 01555 840460

Introduction:

Previous Objectives:

Social Work Analysis of Interventions:

Social Work Objectives and Forward Planning:

Executive Summary:

Content of report discussed with patient?
If yes, date report content was discussed with patient:
If no, please state reason:

Carer's assessment offered?
If yes, date offered:
If no, please state reason:

Referral made?
If yes, date referral was made:
If no, please state reason:

Completed by: **Date:**
(Social Worker)

Countersigned by: **Date:**
(Team Leader)

Social Work Service, The State Hospital, Carstairs ML11 8RP
Tel: 01555 840293 Fax: 01555 840460

THIS REPORT CONTAINS THIRD PARTY INFORMATION Yes/No

SOCIAL WORK REPORT
Intermediate Report

NAME:	**HUB:**
DATE OF BIRTH:	**CHI NO:**
HOSPITAL NO:	**RMO:**

CURRENT LEGAL STATUS:	
ORDER END DATE:	
PQD:	
EDL:	
SED:	
DATE OF ADMISSION:	
ADMITTED FROM:	
INDEX OFFENCE(S):	

Notifiable under Part 2 Sexual Offences Act 2003(2)	
Sex Offender	
Schedule 1 Notification	
Risk to Children	
Subject to MAPPA	
Restricted Patient	
Treated as Restricted	

Named Person *(name, address and telephone details)*	
Primary Carer ***(if different from above)***	
Advance Statement	
Designated MHO *(name, address and telephone details*	
Local Authority	

Social Work Service, The State Hospital, Carstairs ML11 8RP
Tel: 01555 840293 Fax: 01555 840460

Introduction:

Previous Objectives:

Social Work Analysis of Interventions:

Social Work Objectives and Forward Planning:

Executive Summary:

Content of report discussed with patient?
If yes, date report content was discussed with patient:
If no, please state reason:

Completed by: **Date:**
(Social Worker)

Countersigned by: **Date:**
(Team Leader)

Social Work Service, The State Hospital, Carstairs ML11 8RP
Tel: 01555 840293 Fax: 01555 840460

STATE HOSPITAL CPA DOCUMENTATION

(any information that may cause serious harm to the physical or mental health or condition of the patient, or any other person; may disclose information relating to or provided by a third party who has not consented to that disclosure unless the third party is a health professional who has compiled or contributed to the health records or who has been involved in the care of the patient, or the third party who is not a health professional gives their consent to the disclosure of that information, or it is reasonable to disclose without the third parties consent should be placed in the Pre CPA Minute)

	[✓]
ADMISSION CPA	
ANNUAL CPA REVIEW	
INTERMEDIATE CPA REVIEW	
TRANSFER/DISCHARGE CPA	

Patient Name:
CHI No.:
Date of Meeting:
Date of Next Meeting:

	[✓]
ICP Completed	☐
Pre CPA Minute	☐

CORE DOCUMENTS

Care and Treatment Plan
Multidisciplinary Team and Attendees at CPA
Summary of Discussion

MULTIDISCIPLINARY TEAM REPORTS

Psychiatry	☐
Positive and Negative Syndrome Scale	☐
Nursing/Keyworker	☐
Pharmacy	☐
Dietician	☐
Occupational Therapy	☐
Psychological Services	☐
Security	☐
Skye Centre	☐
Social Work	☐
Other (e.g. Drug & Alcohol, or full report from psychological intervention)	☐
Risk Assessment Evidence Document	☐

PATIENT VIEWS

Advance Statement	☐
Staying Well Plan	☐

RISK MANAGEMENT

Violence Risk Assessment and Management Profile	☐
Risk Management Contingency Plan	☐

PATIENT NAME: CHI: DATE OF MEETING:

PATIENT NAME: CHI: DATE OF MEETING:

CPA DOCUMENT (incorporates Part 9 Care Plan)

*Items marked with a * required by statute for Part 9 Care Plan*

Patient Details			
Name:		Date of Birth:	
CHI Number:		Hospital Number:	
Address on Admission (or Sentencing):			
Marital Status		Occupation	
First Language		Religion	
Ethnic Origin (Standard codes)			
Communication Assistance Required		No	

Relationship Details	**Contact Details**
Named Person:	
Relationship to Patient:	
Primary Carer (if different):	
Next of Kin (if different):	

Service Details		
Date of Admission:	Hub:	01555 840293
Responsible Local Authority:		
Responsible Health Board:		

Legal Details	
Legal Status and Section on Admission	Restricted
Current Legal Status and Section	Restricted
Date of Conviction/Insanity Acquittal *	
Date Current Order Began *	
Date of most recent Statutory Review *	
Period during which next Statutory Review must be held (2 month period)*	
Date Sentence Commenced:	
For Determinate Sentences: Earliest Liberation Date/Parole Qualifying Date (For HD/TTD)	
For Life Sentences: Punishment Part	

Driving licence	
Does the patient hold a current driving licence?	Yes/No
If yes, have DVLA been informed of current status? Specify any restrictions in place.	Yes/No

PATIENT NAME: CHI: DATE OF MEETING:

Compulsory Treatment Details			
Compulsory Measures authorised under Mental Health (Care and Treatment) (Scotland) Act 2003		1. Detention in The State Hospital 2. Medical treatment in accordance with Part 16	
Advance Statement: If no, was issue raised with patient?:	Yes/No Date:	Date of T2/T3 Certificate:	
Reasons for decisions or medical treatment which conflict with the Advance Statement.			
Recorded Matters as determined by the Tribunal.			

Patient Subject to Other Legislation		Details and Period of Order
Notifiable under Part 2 Sexual Offences Act 2003 (2) *	Yes/No	
Schedule 1 Notification *	Yes/No	
Risk to Children	Yes/No	
Adults with Incapacity Act (2000). Subject to Welfare or Financial Guardianship	Yes/No	
Adults with Incapacity Act (2000) – Subject to Part IV Management of Patients Finances	Yes/No	
DWP Corporate Appointeeship	Yes	Standard for TSH
Adult Support and Protection (2007) Act	Yes/No	
Power of Attorney	Yes/No	

MAPPA Status	
Is Patient Subject to MAPPA?	
Community Justice Authority and local office	
MAPPA Co-ordinator	Name:
	Telephone no.
Level (Unless otherwise indicated, all State Hospital patients will be level 1)	1

Safeguarding Adults at Risk	
Is the patient likely to pose a specific risk to an adult at risk of harm?	
Is the patient at specific risk of harm from others?	
Adult Protection Co-ordinator:	Name:
	Telephone no:
Outcome of Adult Protection Case Conf:	

PATIENT NAME: CHI: DATE OF MEETING:

Details of those involved in CPA

Clinical Team Members		A/✓	Clinical Team Members		A/✓
RMO* (Care Coordinator)			Social Worker		
Specialty Doctor			Psychologist		
Specialist Trainee			Asst. Psychologist		
Snr Charge Nurse/NTL			Occupational Therapist		
Advanced Nurse Practitioner			Security Manager		
Keyworker			Dietician		
Staff Nurse			Pharmacist		
Skye Centre			Other		

Patient and Named Person	Name	Date Invitation Sent	Attended Meeting (all/part)
Patient			
Named Person			
Carer/Family/Friend			
Advocacy			
Legal Representative			

Local Area Services	Name, Address and Telephone No.	Date Invite sent	A/✓
General Practitioner			
Local Area Forensic Team Representative			
Designated MHO *			
Police Link			
SPS			
Other			

PATIENT NAME: CHI: DATE OF MEETING:

Index Offence
Details of Index Offence:
Brief statement including reason for admission:
Diagnosis

Strengths and protective factors Outline the factors that contribute to resilience or the absence of the problem

Presenting problems and needs Create a problem list which should include matters associated with any distress for the patient; risk and offending behaviour; physical health concerns and any other significant problems

PATIENT NAME: CHI: DATE OF MEETING:

TREATMENT PLAN RECOVERY OBJECTIVES

Recovery Objective	Interventions from care plan dated N/A	Outcome and comments	Revised Action Plan	By whom and by when
1. Improve mental health				
2. Improve physical health and address health promotion				
3. Address any needs associated with diversity (including faith, sexuality, disability and ethnicity) and social inclusion				
4. Address risk assessment and management issues				
5. Tailor security levels and rehabilitation plans to level of risk				
6. Address any family, carer or other relationship issues				

Recovery Objective	Interventions from care plan dated 22.02.18	Outcome and comments	Revised Action Plan	By whom and by when
7. Address any issues associated with capacity				

(e.g. financial and health)				
8. Address rehabilitation and educational needs with a view to enabling Recovery				
9. Address needs associated with personal care and daily living				
10. Address social care and housing needs				
11. Address legal and statutory matters including review of Advance Statement				
12. Develop future plans				

VIEWS AND DISCUSSION FROM MEETING

DISCUSSION OF WEIGHT MANAGEMENT PLAN

VIEWS OF PATIENT

PATIENT NAME: CHI: DATE OF MEETING:

VIEWS OF NAMED PERSON

The Care Plan has been agreed by those present at the multidisciplinary team meeting and signed on behalf of the clinical team

Dr
Specialty Doctor/Trainee
Date signed:

Dr
Consultant (Forensic) Psychiatrist
Date signed:

Distribution List

CPA Portfolio including risk assessment document
RiO, Electronic Patient Record, The State Hospital
Forensic Advisor, Scottish Government
Consultant (Forensic) Psychiatrist in local services
Designated MHO
Social Work Department, The State Hospital (via email)

CPA Core Document only
Patient
Named Person (if permission granted by patient on consent form)

Information collated and typed by:
Date circulated:

PATIENT NAME: CHI: DATE OF MEETING:

1. MDT REPORTS

Professional reports will include recommendations for many potential interventions. The recommendations that are included within the objective section are those that the clinical team have deemed most appropriate to take forward in the next 6 months.

1.1 PSYCHIATRIC – progress update.

Summary of psychiatric input since last review

Recent mental state examination

Side effects of psychotropic medication

Positive and Negative Syndrome Scale Table

Positive and Negative Syndrome Scale Table					
General (G) Factors	**Score (1-7)**	**Positive (P) Factors**	**Score (1-7)**	**Negative (N) Factors**	**Score (1-7)**
Somatic Concerns		Delusions		Blunted Affect	
Anxiety		Conceptual Disorganisation		Emotional Withdrawal	
Guilt Feelings		Hallucinatory Behaviour		Poor Rapport	
Tension		Excitement		Passivity/ Apathy	
Mannerisms and Posturing		Grandiosity		Abstract thinking	
Depression		Supiciousness/ Persecution		Lack of Spontaneity	
Motor Retardation		Hostility		Sterotyped Thinking	
Uncooperativeness		**P Total**		**N Total**	
Unusual Thought Content		Admission/Baseline score and date of assessment			
Disorientation		General Psychopathology Score (P + N + G)			
Poor Attention		Composite Score (P – N)			
Lack of Judgement and Insight		**Previous Score Date (three most recent)**		**Score**	
Disturbance of Volition					
Poor Impulse Control					
Preoccupation					
Active Social Avoidance		**Completed by:**			
G Total		**Date of completion:**			

Positive and Negative Syndrome Scale Interpretation

PATIENT NAME: CHI: DATE OF MEETING:

Recommendations for Care and Treatment Plan

1.2 PHYSICAL HEALTH – progress update.

Specific chronic problems

Weight		Weight Change since last review	
Waist Circumference		BMI	

	✓
Obesity	
Diabetes	
Chronic respiratory problems	
Dyspepsia/reflux	
Blood borne virus	
Constipation	
High Cholesterol	
Hypertension	

Physical Health Summary

1. Blood tests (to be completed at Annual CPA) Full Blood Count: LFT: U & E: TFT: Lipid Profile: Serum Folate & Ferritin: Vitamin D: Blood Glucose (random or fasting): HbA1c (if diabetic): Other:
2. Medical investigations carried out over the last six months (e.g: ultrasound, CT scan, MRI, Echo)
3. Summary of any other hospital admissions during the last six months
4. Latest ECG Report
5. Summary of Annual Health Check (to be completed at Annual CPA)
6. QRISK Score
7. Physical Activity over the Last Six Months (as reported in RiO):
8. Other

PATIENT NAME: CHI: DATE OF MEETING:

Healthy Weight Management Plan

Weight Reduction Interventions to Consider	**Responsibility**	**Recommendations** **Please note if not applicable*
Diet Develop a Nutritional Care Plan, Provide 1:1 Dietary input, Special Diet	Medical / Dietitian	•
Education/Awareness Referral to Healthy Living Group and Healthy Eating Group, participation in Slim and Trim Group	Medical / OT / Skye Centre / Psychology	•
Physical Activity Encouragement or prescription of physical activity, for example: Facilitation of Ward and Hub Activity, Grounds Access, Sports and Gardens placements, animal therapy walks, escorted walks, and use of pedometers	Medical /Nursing/ Skye Centre	•
Pharmacological / Surgical Eg: Metformin, Orlistat, choosing or switching antipsychotic medication with lower propensity of weight gain, and bariatric surgery	Medical/Pharmacy	•

Recommendations for Care and Treatment Plan

Date Report was completed

1.3 KEYWORKER'S EXECUTIVE SUMMARY AND RECOMMENDATIONS

1.4 PHARMACY – EXECUTIVE SUMMARY AND RECOMMENDATIONS

PATIENT NAME: CHI: DATE OF MEETING:

Current Medication

As Required

Sensitivities

High Dose Antipsychotics
Yes/No

% Therapy

Multiple Antipsychotics
Yes/No

Last ECG Date

Qtc (ms) interval

Reference to Medication Changes

Compliance with Consent to Treatment Form

Therapeutic Drug Monitoring

Date	Medication	Dose	Level	Comment

Recommendations from Clinical Pharmacy Report

1.5 DIETITIAN – EXECUTIVE SUMMARY AND RECOMMENDATIONS

1.6 OCCUPATIONAL THERAPY (and Other AHP Therapies) – EXECUTIVE SUMMARY AND RECOMMENDATIONS

1.7 PSYCHOLOGICAL SERVICES – EXECUTIVE SUMMARY AND RECOMMENDATIONS

1.8 SECURITY – EXECUTIVE SUMMARY AND RECOMMENDATIONS

PATIENT NAME: CHI: DATE OF MEETING:

1.9 SKYE CENTRE – EXECUTIVE SUMMARY AND RECOMMENDATIONS

1.10 SOCIAL WORK – EXECUTIVE SUMMARY AND RECOMMENDATIONS

PATIENT NAME: CHI: DATE OF MEETING:

1.11 MULTI-DISCIPLINARY FORMULATION

Predisposing factors and violence risk factors for illness and risk of harm to others Outline early life factors that make a person vulnerable to particular difficulties which contribute to the origins of the underlying mechanism

Precipitating factors and violence risk factors for illness and risk of harm to others Outline events that are close in time to the development of the problem(s) which may play some role in triggering the problem(s)

Perpetuating factors and violence risk factors for illness and risk of harm to others Outline factors that contribute to the problem being maintained

Summary and Underlying Mechanisms Provide a description of the underlying processes (ie psychological, social, medical or other mechanisms that are at work) that describes how the above predisposing, precipitating, perpetuating factors combine to lead to the problems identified

PATIENT NAME: CHI: DATE OF MEETING:

2 VIOLENCE RISK ASSESMENT AND MANAGEMENT PROFILE

2.1 Violence Risk Assessment

Is there a completed violence risk assessment?	
If yes, note type of assessment and date completed:	
Is assessment attached to this treatment plan?	

Possible living situation in next year or likely future transfer plan	

Description of locality/victim issues (if applicable)	

2.2 **Summary** (name each item) of SPJ tool used (e.g. HCR-20, RSVP, START etc)

HCR-20	Definite evidence	Possible evidence	No evidence
Historical Items			
Clinical Items			
Risk management Items			

2.3 Scenario Planning

Describe the nature or kind of violence either within The State Hospital or in the community (when transfer, discharge and suspensions of detention are being considered) that the patient may commit, including risk to children.

2.3.1 The State Hospital

Scenario: hub environment		*Likelihood/ imminence
Most Likely		
Most Serious		
Other possible scenario (e.g. specific victims)		

Scenario: unescorted grounds access		*Likelihood/ imminence
Most Likely		
Most Serious		

Other possible scenario (e.g. specific victims)		

Scenario: Skye Centre (consider specific placements)		*Likelihood/ imminence
Most Likely		
Most Serious		
Other possible scenario (e.g. specific victims)		

Scenario: Child contact; SOD; Telephone; Mail; Possessions; Gifts (received and sent); Other		*Likelihood/ imminence
Most Likely Risk		
Most Serious Risk		
Other possible risk		

2.3.2 Other Possible Scenarios

Scenario: e.g. transfer to a reduced level of security; discharge; hospital appointment; rehabilitation or quality of life suspension of detention		Likelihood/ imminence
Most Likely		
Most Serious		
Other possible scenario (e.g. specific victims)		

Likelihood/imminence

*HIGH: High chance of committing a violent act in situation described – could occur anytime

MEDIUM: Some chance of committing a violent act in situation described – not imminent but scenario could occur if situation were to change.

LOW: Little chance of committing a violent act in the situation described – or not in the foreseeable future

VERY LOW: Almost no chance of committing a violent act in the situation described – scenario described very unlikely to occur.

2.3.3 Warning signs

What warning signs would indicate that this person's risk is increasing or that a violent act may be imminent? List all possible factors.

2.3.4 Risk management recommendations for Care and Treatment plan

Monitoring

- What is the best way to monitor warning signs that this persons risk may be increasing?
- What events, occurrences or circumstances should trigger a reassessment of violence risk?

Treatment

- What treatment or rehabilitation strategies could be implemented to manage the patient's violence risk?
- What deficits in psychological adjustment are high priorities for intervention?

Supervision

- What supervision or surveillance strategies could be implemented to manage the patient's violence risk?
- What restrictions on activity, movement, association or communication are indicated?

Victim safety planning

- What steps could be taken to enhance the security of likely victims?
- How might physical security or self protective skills be improved?

Additional assessments required?

- Detail

2.3.5 Transfer/Discharge or Crisis Management

Risk Management (Traffic Light) Contingency plan required:
Yes/No (If yes, please include with Care and Treatment plan)

PATIENT NAME: CHI: DATE OF MEETING:

2.4 Suicide and self-harm risk assessment

2.4.1 Does the patient have a history of suicide or self-harm? Yes/No
(if yes, provide evidence;)

Rating	Evidence
Yes	
Maybe	
None	

2.4.2 Are there any current risk factors that might suggest an increased risk of self-harm or suicidal behaviours? (refer to: *Suicidal Behaviour Awareness and Good Practice (Guidelines 2006)*:

Risk factors associated with illness	
Psychological risk factors	
Behavioural factors	
Organisational factors	

2.4.3 Suicide and self-harm recommendations for the Care and Treatment Plan

2.5 Current risk management strategies

2.5.1 Summary of risk behaviours:

	Historical (✓)	**In the last 3 months (✓)**
Violence towards others		
Conviction for sexual offence		
Sexually inappropriate behaviour		
Alcohol misuse		
Drug misuse		
Hostage taking		
Absconding or escaping		
Risk of harm to children		
Schedule 1 offence		
Self harm or suicide attempt		
Fire risk		
Use of weapons		
Rooftop incident		
Planning to subvert security and safety		
Severe destruction of property		

2.5.2 Observation level [✓]

When outwith patient bedroom	Standard		Level 2		Level 3	
Patient Bedroom	Locked door (standard)		Level 2		Level 3	

	Yes/No	Detail:
Special measures e.g. seclusion		
Time out / behavioural programme		
Specific adaptation to patient's bedroom		

2.5.3 Drug screen frequency [✓]

Very High – 2 weekly		High - Monthly		3 monthly - Medium		On request	
6 monthly - Low		Annual – Very Low		Other		Random	

2.5.4 Live tailored security measures [✓]

Incoming external mail		Outgoing external mail	
Open, Inspected & Read	☐	Inspected & Read	☐
Open & Inspected	☐	Inspected	☐
Opened in Presence of Staff	☐	Sealed / Unopened	☐

Unsupervised phone calls	Visits	
		High Supervision
		Medium Supervision
		Low Supervision

Grounds access:			Partial:		None	
			Ward Garden	☐		
			Skye Centre	☐		
			Central Area	☐		
Disassociations:		Last Reviewed:				
Tailored room search:						
Please detail if relevant:						

PATIENT NAME: CHI: DATE OF MEETING:

2.5.5 Suspension of detention risk management

Conditions for most recent outing

Date of outing:

Type of outing:

Number of staff	Handcuffs	Schedule 1 (notification required)	Particular locality/victim issues)

Recommendations for future outings

Type of outing:

Note specific outing conditions (e.g. absconding risk, prior behaviour on outings etc).

MAPPA referral required? Yes/No

Number of staff	Handcuffs	Schedule 1 (notification required)	Particular locality/victim issues)

State Hospital Suspension of Detention High Risk Register
Are special Suspension of Detention arrangements required due to press interest? **Yes/No**

2.5.6 Child Protection Summary

Safeguarding Children	
Notifiable under Part 2 Sexual Offences Act 2003 (2)	Yes/No
Schedule 1 Notification	Yes/No
Risk to Children	Yes/No

Does the patient have contact with own or other children? If yes detail		Yes/No
Child's Name	Date of Birth	Relationship to Patient

Social Worker:	Hub:	Ext:
Schedule 1 offence/risk to children history		

PATIENT NAME: CHI: DATE OF MEETING:

Current presentation
Summary of approved child contact

SUMMARY OF APPROVED CHILD CONTACT FOR EACH CHILD
(Enter N/A if no contact is authorised)

Type of contact	Child(ren) Name(s)	Adult(s) authorised to accompany/supervise child(ren)
Child visit to The State Hospital Family Centre		
Patient home visit with child present		
Child contact at other venue		
Telephone Contact		
Video conference etc		

Type of contact	Child(ren) Name(s)	Detail
Other forms of child contact		
Other forms of child contact		
Other forms of child contact		

Additional information and/or support needs (May include family relationship/social factors. Where applicable, please identify the child(ren) which the information relates to)

PATIENT NAME: CHI: DATE OF MEETING:

2.6 Levels of Security and future plans

What is the least restrictive environment that this person could be managed in currently? Describe level of supervision and security needs. Give reasons for special security.

Future Plans	
Is patient being considered for transfer?	Yes/No/N/A
Has a Transfer/Discharge CPA referral been made?	Yes/No/N/A
Give details of future plans.	

The VRAMP has been agreed by those present at the multidisciplinary team meeting and signed on behalf of the clinical team

PATIENT NAME: CHI: DATE OF MEETING:

3. ADMISSION HISTORY

Sources of Information for Admission History

Reason for Admission

Mental State Examination on admission

Past Psychiatric History

Past Forensic History

Family History

Personal and Social History

Allergies

Past Medical History

Previous Head Trauma
Does the patient have a history of TBI that resulted in loss of consciousness? **Yes/No**

Does the patient have a history of TBI that led to hospital admission? **Yes/No**

Drug and Alcohol History

Medication on Admission

Physical Examination on Admission

Mini Mental State Examination on Admission

Investigations at time of Admission

Summary/ Formulation on Admission

Differential Diagnoses on Admission

APPENDIX 1

STATE HOSPITAL CPA PORTFOLIO

PATIENT NAME: **CHI:** **DATE OF MEETING:**

4 HIGHLY CONFIDENTIAL INFORMATION SECTION

The Information below is classified as highly confidential and should not be disclosed to any third party, shared, copied or used for any other purpose without the express permission of the Data Controller

4.1 PSYCHIATRIC

4.2 NURSING

4.3 PHARMACY

4.4 DIETICIAN

4.5 OCCUPATIONAL THERAPY **(**and Other AHP Therapies)

4.6 PSYCHOLOGY

4.7 SECURITY

4.8 SKYE CENTRE

4.9 SOCIAL WORK

4.10 EXTERNAL PARTY

- including factors for and against each, predisposing, precipitating and perpetuating factors.

Progress Update (to be updated at every CPA review)

Dr
Specialty Doctor/Trainee
Date signed:

Dr
Consultant (Forensic) Psychiatrist
Date signed:

Question 3:

Admission assessment form for patients being assessed for admission

This report has been prepared by the Social Work Department at The State Hospital and may contain **Third Party** Information which should not be disclosed without the prior consent of the author of this report

THIS REPORT CONTAINS THIRD PARTY INFORMATION <YES/NO>

SOCIAL WORK PRE ADMISSION ASSESSMENT REPORT

NAME:
DATE OF BIRTH:
HOSPITAL NO: **CHI NO:**

Last Known Address:	
Responsible Local Authority:	

CURRENT LEGAL STATUS:					
				Order End Date:	
				Order End Date:	
PQD		**EDL**		**SED**	
Restricted		**Harm to Children**		**Schedule One Offender**	
ISB		**Subject to MAPPA**		**Sex Offender**	

CURRENT LOCATION	**DATE OF ADMISSION AT CURRENT LOCATION:**

This report has been prepared by the Social Work Department at The State Hospital and may contain **Third Party** Information which should not be disclosed without the prior consent of the author of this report

Criminal Justice Issues	
Remanded/Convicted:	
Index Offence:	
Date of conviction:	
Length of sentence:	

Contact with Local Authority: (where applicable)	
Housing:	
Social Work Department:	
Mental Health Team: Current MHO if applicable	

Known Mental Health Diagnosis:	
Current RMO**:**	
Named Person Details**:**	

Basis of Report

Circumstances Immediately Prior to Admission

Family History

Personal History

Mental Health History

History of Offending

Drug and Alcohol History

Employment History

Current Social Circumstances

Housing/Benefits

Child Protection/Welfare Issues

Victim Issues

Vulnerable Persons/ASP

Client's View of Current Situation

Named Person's / Carer View

MHO View

Assessing RMO View

This report has been prepared by the Social Work Department at The State Hospital and may contain **Third Party** Information which should not be disclosed without the prior consent of the author of this report

Risk Issues

Additional Information

Conclusion and Opinion

Date Referral Received:

Referral Received From:

Allocation Date:

Completed by: **Social Worker** **Date:**

Countersigned by: **Team Leader** **Date:**

THE STATE HOSPITAL
PRE-ADMISSION ASSESSMENT

Patient Name:	**D.O.B/Age:**
Referral Agency:	**Status:**
Assessor:	**Others present:**

REASON FOR REFERRAL:

COGNITIVE ASSESSMENT:

BEHAVIOURAL ASSESSMENT:

.

EMOTIONAL ASSESSMENT:

SEXUAL ASSESSMENT:

JUDICIAL ASSESSMENT:

DRUG /ALCOHOL:

PHYSICAL ASSESSMENT:

PRESENT LIVING ENVIRONMENT:

CURRENT MEDICATION:

RECOMMENDATION:

Signature of Assessing Nurse :

Question 4:

Discharge summary form

TRANSFER/DISCHARGE SUMMARY

NAME: **HUB:**

DATE OF BIRTH: **CHI NO:**

HOSPITAL NO: **RMO:**

LEGAL STATUS ON DISCHARGE:	
PQD:	
EDL:	
SED:	
DATE OF ADMISSION:	
ADMITTED FROM:	
INDEX OFFENCE(S):	

Notifiable under Part 2 Sexual Offences Act 2003(2)	
Sex Offender	
Schedule 1 Notification	
Risk to Children	
Subject to MAPPA	
Restricted Patient	
Treated as Restricted	

Named Person *(name, address and telephone details)*	
Advance Statement	
Designated MHO *(name, address and telephone details*	

Social Work Service, The State Hospital, Carstairs ML11 8RP
Tel: 01555 840293 Fax: 01555 840460

Transfer/Discharge Destination:

Circumstances Immediately Prior to Admission:
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Social Work Involvement:

Outstanding Issues:

Date of Latest CP Summary:	**Up-to-Date and Complete:**
Completed by: **(Social Worker)**	**Date:**
Countersigned by: **(Team Leader)**	**Date:**

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